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# States Spotlight Promising Fixes to the No Surprises Act

Since a bipartisan majority in Congress passed the No Surprises Act (NSA) more than five years ago, the law has been instrumental in preventing an estimated 50 million surprise medical bills from reaching patients.[1] Yet, while the law provides a significant consumer protection, it also includes a major loophole that leads to inflated payments to providers, ever-increasing health care prices and spikes in coverage premiums. At issue is how the NSA determines payments for out-of-network providers, relying on a gameable independent dispute resolution (IDR) process.[2] In the absence of a firm, evidence-based price benchmark to determine appropriate out-of-network payments, provider staffing firms backed by private equity and corporate middlemen have been able to exploit the NSA's IDR process to create a lucrative business model. These firms systematically flood arbitrators with millions of disputes every year, many of which are not even eligible for arbitration,[3] and these firms win nearly 90% of IDR decisions and earn massive financial rewards.[4]

Without action to strengthen the NSA against industry abuse, inflated IDR payment awards will significantly raise health care costs across the health care system and directly raise costs for consumers when insurers pass along those costs in the form of premium rate increases.[5] **The good news is these abuses and inflated prices can be avoided, as shown by the experience of key states across the country that have enacted successful state surprise billing laws.**[6]

## State Policies That Protect Patients and Prevent Inflated Payments

CALIFORNIA | OHIO | VIRGINIA

**California's, Ohio's and Virginia's surprise medical billing laws have key guardrails that effectively set out-of-network (OON) payment rates (for example, through a fixed evidence-based benchmark like percent of Medicare).**

**KEY PAYMENT GUARDRAILS**

- Set default payments to OON providers using an evidence based benchmark (e.g., percent of Medicare).
- Require OON providers to use an insurers' appeals process before accessing arbitration.
- Set strict limits on how frequently providers can access arbitration.

**RESULTS**

1. Protect patients from surprise bills.
2. Provide fair payment to providers for out-of-network care.
3. Contain health care costs.

*California, Ohio and Virginia — which span the political spectrum — clearly show it is possible to solve for surprise medical bills while designing a payment process resistant to industry abuse and gaming.*

Twenty-two states have enacted their own state laws to address surprise billing and out-of-network payments for medical services.[7] States like California, Ohio and Virginia designed their surprise billing reforms with key guardrails that both protect their residents from surprise bills at the point of care and effectively set out-of-network payment rates between insurers and providers without making the law prone to industry gaming.

These states — which span the political spectrum — clearly show it is possible to solve for surprise medical bills while designing a payment process resistant to industry abuse and gaming. In the states described below, people are protected from surprise medical bills, providers are paid, and care is provided. In contrast to the federal No Surprises Act process, the number of appeals is in the hundreds rather than the millions; arbitration rulings are closer to an even split between providers and payers; and in some cases, health care costs are lowered rather than raised.

As members of Congress weigh reforms to address ongoing challenges with the federal IDR process, they should look no further than the states that have enacted and scaled successful surprise billing reforms. **Below are key details of three notable state approaches that show promise in resolving out-of-network payment disputes while holding patients harmless, as well as one state approach that serves as a cautionary tale.**

## Promising state examples

### CALIFORNIA

California's surprise billing law went into effect on July 1, 2017. It sets out-of-network payments using a strong evidence-based pricing benchmark, requiring insurers to pay out-of-network providers the greater of 1) the average contracted rate paid by the insurer for the same or similar services in the same geographic area or 2) 125% of the Medicare rate.[8] This default payment standard serves as a key guardrail that prevents provider groups from exploiting the system and charging inflated out-of-network payments. Moreover, California's law puts in place another critical guardrail against providers submitting high numbers of ineligible disputes by requiring providers to first use an insurer's internal appeals process prior to accessing the state-run IDR process when disputing out-of-network payments.[9] Overall, the law's strong payment benchmark is lowering health care costs for California residents. Since enactment, out-of-network provider charges decreased by $752 — or 25% — compared with other states without such strong surprise billing laws.[10] At the same time, only 269 payment disputes between insurers and providers have reached California's IDR process between 2018 and the second quarter of 2025, the most recent data publicly available.

## OHIO

In 2020, Ohio lawmakers passed a surprise billing law that utilizes a default benchmark for setting payments for covered services between out-of-network providers and state-regulated insurers. Ohio law now requires insurers to pay providers the greater of 1) the median in-network rate for the same service in the same geographic region, 2) the out-of-network rate paid by the insurer or 3) the Medicare rate.[11] In cases when providers do not accept the insurer's payment and seek arbitration, third-party arbitrators are required primarily to consider in-network rates paid by the insurer and other insurers in the same geographic area.[12] The law also explicitly restricts such third-party entities from considering providers' inflated gross charges (that is, list prices) when making payment determinations.[13] The use of in-network rates both for setting the default payment benchmark and during arbitration collectively help to prevent out-of-network payments from far exceeding typical payments for in-network and out-of-network services. At the same time, among the small number of cases (578) that reached Ohio's state-run IDR in 2023, just 60% of those cases resulted in payment awards favoring providers, compared with roughly 78% at the federal level in 2023.[14]

## VIRGINIA

Virginia's surprise billing law requires insurers to offer out-of-network providers a "commercially reasonable amount" based on payments for the same or similar services provided in a similar geographic area.[15] Most notably, Virginia's surprise billing law includes strong guardrails against industry gaming of the state's arbitration system, forbidding insurers or providers from initiating arbitration with "such frequency as to indicate a general business practice." Virginia then used this statutory authority to set strict regulatory limits on the total number of arbitration requests providers could submit: no more than one arbitration request per provider group during a seven-day period.[16]

As a result, between May 2024 and May 2025, Virginia's IDR system processed just 252 cases, compared with more than 34,000 federal NSA cases processed from Virginia during the same period.[17] Virginia's arbitration system also generates more balanced payment rewards, siding with providers less frequently than at the federal level. Between May 2024 and May 2025, providers won 45% of disputes through Viriginia's IDR process, but providers won roughly 85% of disputes through the federal No Surprises Act IDR process during the same time frame.[18] In addition, Virginia's process proved to be significantly less inflationary, generating average awards of $439 for emergency medicine providers in the fourth quarter of 2024, compared with average awards of $2,268 for emergency services — more than five times higher — through the federal IDR process for the same period.[19]

## A cautionary state tale


Similar to the federal No Suprises Act — and in stark contrast to the examples set by California, Ohio and Virginia — other state laws to prevent surprise billing highlight the perils of failing to set a reliable and appropriate benchmark.

New York gets credit for passing one of the earliest state surprise billing laws in October 2014. It primarily relies on a state IDR process to settle payment disputes between out-of-network providers and insurers with no default payment benchmark. Most notably, New York law requires third-party arbitrators in the state IDR process to consider the 80th percentile of billed charges for a particular health service in addition to other factors, such as the median in-network rates.[20] Because billed charges are inflated prices unilaterally set by providers that no insurer actually pays, and are largely untethered to market-based negotiated rates,[21] average out-of-network charges increased significantly (by $1,157, or 24%) after passage of New York's surprise billing law.[22] Moreover, as of 2024, providers won more than 80% of cases in the state's arbitration system, compared with roughly 85% of cases won by providers in the federal IDR process in 2024.[23] Other states, such as New Jersey, which also allowed billed charges to be considered by arbitrators in state IDR processes, saw similar outcomes and rising health care costs.[24]

To address these outcomes, New York adjusted the state law in 2026. Starting August 26, 2026, arbitrators adjudicating cases involving the state employee health plan shall choose whichever offer is closest to the 50th percentile of all in-network rates for that service among providers in the same or similar specialty and in the same geographical area.[25]

*Similar to the federal No Suprises Act — and in stark contrast to the examples set by California, Ohio and Virginia — other state laws to prevent surprise billing highlight the perils of failing to set a reliable and appropriate benchmark.*

## The path forward

As detailed in a companion Families USA paper, *Congress Must Act to Safeguard the No Surprises Act from Industry Gaming*, abuse of the federal IDR system and consistently high payment awards to providers now threaten to raise costs for patients across the country. To protect against this threat, Congress must reevaluate the process for determining out-of-network payment disputes between providers and insurers while preserving the No Surprises Act's ironclad consumer protections that are effective in keeping surprise medical bills from reaching patients. Due to Employee Retirement Income Security Act (ERISA) preemption, state laws alone cannot protect all patients from surprise medical bills, including the two-thirds of workers who rely on self-funded health plans in the United States. As such, federal lawmakers must take action to reform federal protections from surprise medical bills, including the No Surprises Act. As exemplified in well-designed state laws, reforms to the No Surprises Act should include:

- **A statutorily defined payment standard for the initial out-of-network payment** that is at least one of the following:
  - Based on usual in-network or out-of-network rates paid by the insurer.
  - Defined as a percentage of the Medicare rate.
- **Guardrails to prevent abuse of IDR**, such as:
  - Limits to the frequency of use.
  - A minimum dollar amount for eligible disputes.
- **A statutory requirement to develop a database of in-network and out-of-network rates** for eligible health care services that arbitrators must use to determine fair payments in the IDR process.

## Congress must act

**We urge Congress to act swiftly to close loopholes in the No Surprises Act and strengthen this landmark consumer protection law, which has protected millions of patients from receiving surprise medical bills.**

# Appendix 1. Comparison of Select State Surprise Billing Laws

Blue text = cost containment positive policy design  Red, italic text = inflationary policy design

| STATE | CALIFORNIA | NEW YORK | OHIO | VIRGINIA |
|---|---|---|---|---|
| **Statutory authority** | California Code, California Health and Safety Code § 1371.30[26] | N.Y. Comp. Codes R. & Regs. Tit. 23 § 400.5[27] | Ohio Revised Code §§ 3902.50–3902.54[28] | Code of Virginia, Title 38.2 Insurance, §§ 38.2-3445.01 through 38.2-3445.07[29] |
| **Applicable insurers** | State-regulated health plans, excluding Medicaid managed care plans.[30] | State-regulated health plans, including Medicaid managed care plans. | State-regulated health plans. | State-regulated health plans, state employee health plans, and self-funded plans that have voluntarily opted into this Virginia law.[31] |
| **Patient protections** | **Yes.** Restricts out-of-network providers from balance billing patients for services delivered at an in-network facility.<br><br>Health plans are required to align cost-sharing requirements for the services listed above with the in-network rate, unless the patient provides written consent to billing.[32]<br><br>Note: Due to a California Supreme Court case, providers may not balance bill for out-of-network emergency services. | **Yes.** Restricts providers from surprise billing patients for 1) out-of-network emergency services, 2) covered services delivered by an out-of-network provider at an in-network hospital or ambulatory surgery center, where an in-network provider is unavailable and without the patient's knowledge, 3) covered services delivered by an out-of-network provider based on a referral from an in-network provider without written consent from the patient, and 4) noncovered services delivered by a physician, hospital or ambulatory surgery center, where the patient was not provided timely notice or warning.[33]<br><br>Health insurers are required to align cost-sharing requirements for the services listed above to the in-network rate.[34] | **Yes.** Restricts out-of-network providers from balance billing patients for 1) emergency services provided at an out-of-network facility, 2) emergency services provided by an out-of-network ambulance, and 3) unanticipated out-of-network care provided at an in-network facility.<br><br>Health plans are required to align cost-sharing requirements for the services listed above to at least the in-network rate.[35] | **Yes.** Restricts out-of-network providers from balance billing patients for 1) emergency services and 2) nonemergency services provided to a patient at an in-network facility if such nonemergency services involve surgical or ancillary services provided by an out-of-network provider.[36]<br><br>Health plans are required to align cost-sharing requirements for the services listed above to the in-network rate, based on the "median in-network contracted rate" for the same or similar services in the same or similar geographic area.[37] |

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| **Out-of-network payment standard** | **Yes.** Health insurers must pay out-of-network providers the greater of 1) the average contracted rate paid by the insurer for the same or similar services in the same geographic area or 2) 125% of the Medicare fee-for-service rate.[38] | **No.** *In certain cases, health insurers by default must pay out-of-network providers an undefined "reasonable" fee for emergency services, or for nonemergency services, the insurer shall pay the billed amount or "attempt to negotiate reimbursement."*[39]<br><br>For hospital payments for emergency services, health insurers are required to pay at least 25% more than the payment rate based on the most recent contract between the plan and hospital.[40] | **Yes.** Health insurers by default must pay out-of-network providers the greater of 1) the median in-network rate for the services for that applicable geographic region, 2) the health insurer's out-of-network rate for the service, also known as the usual, customary and reasonable rate for such services, and 3) the Medicare rate.[41] | **Yes.** Health insurers must offer to pay out-of-network providers a "commercially reasonable amount" based on payments for the same or similar services provided in a similar geographic area, within 30 days of receiving a claim/bill from such provider.[42] |
| **Payment arbitration process (for example, IDR)** | **Yes.** IDR entities are required to consider any information submitted by the relevant parties as well as the factors below when making a payment decision:[43]<br>• The provider's training and qualifications.<br>• The nature of the services provided.<br>• *The fees usually charged by the provider for the type of service.*<br>• *The fees usually charged by similar providers for the service in the geographic area in which the services were rendered.*<br>• In limited circumstances: negotiated rates for the same services as listed in a 3rd party all payer claims database. | **Yes.** The IDR entity shall select either the health plan's payment or provider's fee, and is required to make a decision within 30 business days and consider the following factors in determining what is a "reasonable fee":[44]<br>• Whether there is a "gross disparity" between the provider's charges and the payments from out-of-network insurers and other insurer payments made to other "similarly qualified" out-of-network providers for the same services in the same region.<br>• The provider's training.<br>• Complexity of the particular case.<br>• Median in-network rates for similarly qualified providers for the same or similar services.<br>• *With regard to physician services, the usual and customary cost of the service (that is, the 80th percentile of all provider charges for the particular health care service performed by a provider in the same specialty and geographic area).* | **Yes.** IDR entities are required to render a decision within 30 days, determining which payment offer reflects a "fair reimbursement rate," after considering the evidence submitted by both parties, including the following factors:[45]<br>• In-network rates paid by the health plan and other health plans.<br>• Whether the health plan and the provider had a prior contractual relationship within the past six years.<br>• Documentation submitted from previous arbitration cases (if applicable).<br><br>Note: No party may submit "billed charges" or public payer rates as evidence for IDR consideration. | **Yes.** IDR entities are required to consider the following factors:<br>• Evidence and methodology submitted by parties.<br>• Patient characteristics and circumstances of the case.<br>• Datasets provided by a benchmarking database selected by the Virginia commissioner (that is, Virginia's all-payer claims database).[46] |

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| **Other guardrails and miscellaneous** | Out-of-network providers who dispute the initial payment provided are first required to pursue the plan's internal appeals process prior to submission to IDR.[47] | If the IDR entity determines that a private settlement between the plan and provider is likely or that the plan's payment and provider's fee represent "unreasonable extremes," then the entity may direct both parties to attempt good faith negotiation for settlement.<br><br>Note: Starting August 26, 2026, IDR entities adjudicating cases involving state employee health benefit plan shall choose between the provider's or plan's payment depending on which is closer to the 50th percentile of all in-network rates for the particular service among providers with the same or similar specialty and in the same geographical area, with certain exceptions.[48] | Prior to IDR arbitration, the parties must spend 30 days negotiating a reimbursement rate. | Virginia applies a good faith negotiation period of 30 days, after which either party may escalate the case as an IDR dispute.<br><br>Virginia law forbids insurers or providers from initiating arbitration with "such frequency as to indicate a general business practice."[49]<br><br>The law also established a total limit for eligible arbitration requests: no more than one arbitration request per provider group (or sole health care professional not part of provider group) during a seven-day period — defining such limit as an aggregate limit, regardless of geographic area, service/CPT code or insurer involved.[50] |

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# Endnotes

[1] This estimate assumes the No Surprises Act has prevented more than 1 million surprise bills per month in the months since January 2022, when the law went into effect. See "No Surprises Act Continues to Prevent More Than 1 Million Surprise Bills Per Month, While Provider Networks Grow," AHIP and Blue Cross Blue Shield Association, January 2024, https://www.ahip.org/resources/no-surprises-act-continues-to-prevent-more-than-1-million-surprise-bills-per-month-while-provider-networks-grow.

[2] "NYT: Provider-Driven Abuse an 'Expensive Unanticipated Consequence' of No Surprises Act," AHIP, April 23, 2026, https://www.ahip.org/news/articles/nyt-provider-driven-abuse-an-expensive-unanticipated-consequence-of-no-surprises-act; Matt McGough et al., "How Much and Why ACA Marketplace Premiums Are Going Up in 2027," Peterson-KFF Health System Tracker, July 8, 2026, https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2027/.

[3] Jack Hoadley et al., "The No Surprises Act IDR Process: An Early Look at 2025 Data," *Health Affairs Forefront,* March 20, 2026, https://www.healthaffairs.org/content/forefront/no-surprises-act-idr-process-early-look-2025-data.

[4] These figures are from the first and second quarters of 2025. See "Independent Dispute Resolution Reports," U.S. Centers for Medicare & Medicaid Services (CMS), CMS.gov, page last modified July 27, 2026, https://www.cms.gov/nosurprises/policies-and-resources/reports; "Requirements Related to Surprise Billing; Part II," *Federal Register* 86, no. 192 (October 7, 2021): 56056, https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii#citation-187-p56056; Hoadley et al., "The No Surprises Act IDR Process."

[5] These figures are from the first and second quarters of 2025. See CMS, "Independent Dispute Resolution Reports."

[6] Courtney B. Baggett, Cassandra R. Cole, and Natalia Tunajek, "Causes and Consequences of Surprise Billing and What States Are Doing About It," *Journal of Insurance Regulation* 45, no. 2 (2026), https://content.naic.org/sites/default/files/jir-45-2.pdf.

[7] "Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process," U.S. Centers for Medicare & Medicaid Services, n.d., https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf.

[8] California Code, Health and Safety Code § 1371.31, https://law.justia.com/codes/california/code-hsc/division-2/chapter-2-2/article-5/section-1371-31/?__cf_chl_f_tk=X5.evVngSwKsaqBVQjEua_061yDXI4SpDbZtsNXhEXY-1782929884-1.0.1.1-pPJGd8Dqq1fjr3LjVTdDVER6XcdOshtHVQL9aARPQCA; California State Assembly, "Health Care Coverage: Out-of-Network Coverage," Assembly Bill No. 72 (2016), https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201520160AB72&showamends=false.

[9] California Code, Health and Safety Code § 1371.31; California State Assembly, "Health Care Coverage: Out-of-Network Coverage," Assembly Bill No. 72 (2016).

[10] Aliza S. Gordon et al., "Provider Charges and State Surprise Billing Laws: Evidence From New York and California," *Health Affairs* 41, no. 9 (2022): 1316–1323, https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01332.

[11] "Surprise Billing FAQs," Ohio Department of Insurance, n.d., https://insurance.ohio.gov/consumers/surprise-billing/resources/01-surprise-billing-faqs; Ohio Revised Code § 3902.51, (2021) https://codes.ohio.gov/ohio-revised-code/section-3902.51.

[12] Ohio Department of Insurance, "Surprise Billing FAQs"; Ohio Revised Code Section 3902.51, (2021).

[13] Ohio Department of Insurance, "Surprise Billing FAQs"; Ohio Revised Code Section 3902.51, (2021).

[14] *2023 Ohio Surprise Billing Arbitration: Annual Report* (Columbus, Ohio: Ohio Department of Insurance, n.d.), https://dam.assets.ohio.gov/image/upload/insurance.ohio.gov/Consumer/Surprise%20Billing/2023_Surprise_Billing_Arbitration_Annual_Report.pdf; CMS, "Independent Dispute Resolution Reports."

[15] Code of Virginia § 38.2-3445.01, https://law.lis.virginia.gov/vacode/title38.2/chapter34/section38.2-3445.01/.

[16] Code of Virginia § 38.2-3445.01.

[17] Hoadley et al., "The No Surprises Act IDR Process"; *Health Insurance Balance Billing Arbitration: Annual Report* (Virginia State Corporation Commission, Bureau of Insurance, July 2025), https://rga.lis.virginia.gov/Published/2025/RD363/PDF; CMS, "Independent Dispute Resolution Reports."

[18] Hoadley et al., "The No Surprises Act IDR Process"; Virginia State Corporation Commission, *Health Insurance Balance Billing Arbitration*; CMS, "Independent Dispute Resolution Reports."

[19] Virginia State Corporation Commission, *Health Insurance Balance Billing Arbitration; Anthem Health Plans of Virginia Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc. v. AGS Health, Inc. et al.,* Case No. 7:25-cv-00804, U.S. District Court, Western District of Virginia Division, https://litigationtracker.law.georgetown.edu/wp-content/uploads/2025/12/Anthem-Health-Plans_2025.11.05_COMPLAINT.pdf; CMS, "Independent Dispute Resolution Reports."

[20] Consolidated Laws of New York, Chapter 18-A, Article 6, https://www.nysenate.gov/legislation/laws/FIS/A6.

[21] Benjamin L. Chartock et al., "Arbitration Over Out-of-Network Medical Bills: Evidence From New Jersey Payment Disputes," *Health Affairs* 40, no. 1 (2021): 130–137, https://doi.org/10.1377/hlthaff.2020.00217.

[22] Gordon et al., "Provider Charges and State Surprise Billing Laws."

[23] There were 1,712 cases won by plans and 7,198 cases won by providers in 2024 in the state of New York. See *Consumer Protection and Financial Enforcement Division Annual Report* (New York State Department of Financial Services, March 15, 2025), https://www.dfs.ny.gov/system/files/documents/2025/03/nysdfs-2024-cpfed-annual-rpt-20250315.pdf.

[24] Chartock et al., "Arbitration Over Out-of-Network Medical Bills."

[25] There are certain exceptions to this process. In cases where the physician is employed by a general hospital or is part of a group practice that is established as a captive professional services corporation whose shareholders are employees of such hospital, the IDR entity shall consider the original list of factors as listed above. Moreover, the IDR entity may depart from the benchmark (50th percentile rate) if the parties' submissions are equally distant from it, or if factors such as the provider's training and experience, the complexity of the case, or individual patient characteristics clearly demonstrate that the benchmark is not the appropriate payment. However, in no circumstances, can the payment determination exceed the 80th percentile of all in-network rates for such service(s). See "New York Overhauls State Independent Dispute Resolution Process," Garfunkel Wild, June 3, 2026, https://garfunkelwild.com/insights/new-york-overhauls-state-independent-dispute-resolution-process/; Consolidated Laws of New York, Chapter 18-A, Article 6, Section 604, https://www.nysenate.gov/legislation/laws/FIS/604.

[26] California Code, Health and Safety Code § 1371.30, https://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1371-30/.

[27] New York Compilation of Codes, Rules & Regulations, Title 23 § 400.5, https://www.law.cornell.edu/regulations/new-york/23-NYCRR-400.5.

[28] Ohio Revised Code § 3902.50, https://codes.ohio.gov/ohio-revised-code/section-3902.50.

[29] Code of Virginia, § 38.2-3445.01, https://law.lis.virginia.gov/vacode/title38.2/chapter34/section38.2-3445.01/.

[30] "Non Emergency Services Independent Dispute Resolution Process (AB 72 IDRP)," California Department of Managed Health Care, n.d., https://www.dmhc.ca.gov/fileacomplaint/providercomplaintagainstaplan/nonemergencyservicesindependentdisputeresolutionprocess.aspx.

[31] Code of Virginia, § 38.2-3445.01.

[32] Erin L. Duffy, "Influence of Out-of-Network Payment Standards on Insurer–Provider Bargaining: California's Experience," *American Journal of Managed Care* 25, no. 8 (2019): e243-e246, https://www.ajmc.com/view/influence-of-outofnetwork-payment-standards-on-insurer-provider-bargaining-californias-experience; California State Assembly, "Health Care Coverage: Out-of-Network Coverage," Assembly Bill No. 72 (2016), https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201520160AB72&showamends=false.

[33] Consolidated Laws of New York, Chapter 18-A, Article 6, Section 606, https://www.nysenate.gov/legislation/laws/FIS/606.

[34] Consolidated Laws of New York, Chapter 18-A, Article 6, Section 605, https://www.nysenate.gov/legislation/laws/FIS/605.

[35] Ohio Revised Code § 3902.51, https://codes.ohio.gov/ohio-revised-code/section-3902.51.

[36] Code of Virginia, § 38.2-3445.01.

[37] Code of Virginia, § 38.2-3445.01.

[38] California Code, Health and Safety Code § 1371.31; California State Assembly, Assembly Bill No. 72 (2016).

[39] New York Compilation of Codes, Rules & Regulations, Title 23 § 400.5.

[40] New York Compilation of Codes, Rules & Regulations, Title 23 § 400.5.

[41] "Surprise Billing FAQs," Ohio Department of Insurance, n.d., https://insurance.ohio.gov/consumers/surprise-billing/resources/01-surprise-billing-faqs; Ohio Revised Code § 3902.51.

[42] State law requires Virginia to contract with a nonprofit data services organization to establish the dataset (using commercial health claims data in 2020 and adjusted by the consumer price index over time) and processes for providing health insurers, health care providers and arbitrators with data to assist in determining commercially reasonable payments and resolving payment disputes. State law requires such dataset and processes to be developed in collaboration with health insurers and providers. See Code of Virginia, § 38.2-3445.01; Code of Virginia, § 38.2-3445.03, https://law.lis.virginia.gov/vacode/title38.2/chapter34/section38.2-3445.03/.

[43] California Code, Health and Safety Code § 1371.31, https://law.justia.com/codes/california/code-hsc/division-2/chapter-2-2/article-5/section-1371-31/?__cf_chl_f_tk=X5.evVngSwKsaqBVQjEua_061yDXI4SpDbZtsNXhEXY-1782929884-1.0.1.1-pPJGd8Dqq1fjr3LjVTdDVER6XcdOshtHVQL9aARPQCA; California State Assembly, Assembly Bill No. 72 (2016).

[44] Consolidated Laws of New York, Chapter 18-A, Article 6, Section 605. Note: Starting August 26, 2026, the IDR entity will have 45 days to make a determination.

[45] Ohio Revised Code § 3902, https://codes.ohio.gov/ohio-revised-code/section-3902.52.

[46] Code of Virginia, § 38.2-3445.03.

[47] California Code, Health and Safety Code § 1371.31; California State Assembly, Assembly Bill No. 72 (2016).

[48] In cases where the physician is employed by a general hospital or is part of a group practice that is established as a captive professional services corporation whose shareholders are employees of such hospital, the IDR entity shall consider the original list of factors as listed above. Moreover, the IDR entity may depart from the benchmark (50th percentile rate) if the parties' submissions are equally distant from it, or if factors such as the provider's training and experience, the complexity of the case, or individual patient characteristics clearly demonstrate that the benchmark is not the appropriate payment. However, in no circumstances, can the payment determination exceed the 80th percentile of all in-network rates for such service(s). See "New York Overhauls State Independent Dispute Resolution Process," Garfunkel Wild, June 3, 2026, https://garfunkelwild.com/insights/new-york-overhauls-state-independent-dispute-resolution-process/; Consolidated Laws of New York, Chapter 18-A, Article 6, Section 604, https://www.nysenate.gov/legislation/laws/FIS/604.

[49] Scott A. White, "Compliance with Virginia's Arbitration Process for Balance Billing Claims," Administrative Letter 2021-04, Commonwealth of Virginia, Bureau of Insurance, November 22, 2021, https://www.scc.virginia.gov/media/sccvirginiagov-home/regulated-industries/insurance/insurance-companies/life-health-companies/balance-billing/21-04.pdf; Code of Virginia, § 38.2-3445.05, https://law.lis.virginia.gov/vacode/title38.2/chapter34/section38.2-3445.05/.

[50] White, "Compliance with Virginia's Arbitration Process."

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